BlueCross BlueShield of Illinois

A Division of Health Care Service Corporation,
a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association
300 East Randolph Street, Chicago, IL 60601

Sign up for **Blue Dental Plus**℠.

To be considered for coverage, you must have Medicare Parts A and B, and you must reside in Illinois.

To help us process your application, be sure to:

- Answer **all** questions.
- Include payment details.
- Sign the application.
- Print all answers in **blue or black ink**.
- If you need to change any answers, cross out what you are changing and add your initials by the new answer. Do not use correction fluid or tape.

Tell us about you.

Applicant[1]			
First Name, Middle Initial, Last Name			
Home Address - Street, City, State, ZIP Code (No P.O. Box)			**County**
Mailing Address (If different from Home Address)			
Social Security Number	**Sex** M F	**Date of Birth**	**Phone Number**

Choose your dental plan.

Review your options below, **select ONE plan only, and enter a requested effective date:**

Blue Dental Plus	Individual Deductible	Effective Date
☐ Standard	$75	___/01/___
☐ Premier	$50	___/01/___

You may be eligible for a discount if you are enrolled in a Blue Cross and Blue Shield of Illinois Medicare Supplement policy. The discount is 5%.

Are you applying for this discount? Y N

If yes, provide your BCBSIL Medicare Supplement subscriber ID: _____

[1] Age 18 and older.

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Proxy Statement (Optional)

By purchasing a Blue Cross and Blue Shield of Illinois dental plan, I become a member of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). By signing this application, I ask the Board of Directors of HCSC to act on my behalf at all meetings of members of HCSC. I understand that:

- This permission will apply to any company that replaces HCSC
- The Board of Directors may appoint someone to vote for me

The annual meeting of members is scheduled to take place each year in the corporate headquarters (300 E. Randolph St., Chicago, IL 60601) on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called if needed. Notice of any special meeting will be given within 30-60 days before the meeting.

My assignment of my member vote to the Board of Directors will be in effect:

- Until or if I cancel it in writing at least 20 days before any meeting of members, or
- Unless I attend and vote in person at any meeting of members.

Applicant's (your) proxy signature: **NOTE:** Whether you sign for proxy or not, you must sign on page 3 to complete this application.	**Date**
Print your name as you signed it:	

Tell us how you will make your payments.

Payment Option (Select one payment option)

1. Premium **deducted from bank account** (choose one): ☐ **Checking** ☐ **Savings**

Account holder name:	
Bank name:	
Bank routing number:	Bank account number:
Account owner signature (if different than applicant)	

Bank Draft Authorization Agreement

By signing this application, I request and authorize BCBSIL and/or its designee to obtain payment of amounts becoming due by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the financial institution named below to accept and honor the same to my account.

I understand that this request for coverage is not an employer group health plan and is not intended, in any way, to be an employer sponsored health insurance plan. I certify the employer(s) of those applying for coverage will not contribute any part of the premium or provide reimbursement for any part of the premium now or in the future. I also understand that both the financial institution and BCBSIL reserve the right to terminate this payment program and/or my participation therein. To make changes to my financial institution I understand that I will need to provide at least 10 days advanced notice to BCBSIL by telephone prior to a scheduled withdrawal date. I authorize BCBSIL to deduct the premium payments from my checking or savings account. If the draft date falls on a non-business day or a holiday, the premium payment will be deducted from my account on the next business day.

2. ☐ Premium **to be billed by mail**

Medicare Beneficiary Identifier

Please copy the Medicare Beneficiary Identifier from your red, white and blue Medicare Card. This number must be provided to us to complete your application process.

Medicare Beneficiary Identifier ☐☐☐☐☐☐☐☐☐☐☐	
Part A Effective Date:	Part B Effective Date:

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Acknowledgements and Signature
1. I hereby apply for coverage and request a policy to review for the policy indicated.
2. I understand that once my first premium payment is received, I will be covered as of the date shown on the Company identification card. Services are covered only when received on or after the effective date of the policy chosen.
3. I hereby declare that the statements and answers on this application are true and complete to the best of my knowledge and belief. I agree that the Company, believing them to be true, shall rely and act upon them accordingly. I hereby agree to furnish any additional information, if requested.
4. I understand that the Company has the right to reject my application. If the Company rejects my application, I will be notified in writing. If this application is accepted, it will become part of the insurance policy.
5. I acknowledge that any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of a felony.
6. I acknowledge that any agent is acting on my behalf for purposes of purchasing the insurance, and that if the Company accepts this application and issues an individual policy, the Company may pay the agent a commission and/or other compensation in connection with the issuance of such individual policy.
7. I acknowledge if I desire additional information regarding any commissions or other compensation paid to the agent by the Company in connection with the issuance of the individual policy, I should contact the agent.

Please read and sign below.

Your signature makes this a contract if/when fully processed	
Applicant's Signature	**Date**
If this authorization is signed by a personal representative on behalf of an individual, complete the following:	
Personal Representative's Name (Please Print)	**Relationship:**
Do you permit any other adult named on this form to answer questions about this form? If you are the legal guardian, please enclose the signed court decree. If you have the Power of Attorney, please submit that paperwork. ☐ Y ☐ N	

Did you work with an agent?

Agents, complete this section (if applicable)		
I certify that: • I provided the application to the Applicant for completion, or I personally asked the questions and recorded the answers as given. • I provided written material to explain the benefits to the Applicant. This includes details about what may not be covered and any special details about their coverage. • I have reviewed the required plan document(s) with the Applicant. This includes the Disclosure Statement(s) when requested.		
Agent's Signature	**Date**	**Agent ID**
Print Agent's Name	**Agent's Phone**	
Agent's Email		

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Send us your application.

To make sure your form is processed as quickly as possible, don't forget to:

- Sign your form.
- Send all pages of the form, even if some are blank.
- If you are working with an agent at BCBSIL, please include your agent's information above.

Send by mail	**Return to your agent or send this application to:** Blue Medicare Supplement c/o Member Services P.O. Box 3388 Scranton, PA 18505

Questions?	If you have any questions, please call your agent or call BCBSIL toll-free at 877-384-9297.

Please include all necessary materials when submitting this application.

If you are the legal guardian, please enclose the signed court decree.
Call 877-384-9297 for questions about membership, payments, and benefits.